Sub-Mucous Cleft Palate – Case Histories


The occurrence of Sub-mucous Cleft Palate is rare, but even so, it is vitally important that the speech therapist be aware of the condition as a possible cause of nasal speech. She should be able to recognise the symptoms which lead to its diagnosis and refer all suspected cases to a surgeon who deals with cleft lip and palate for consultation before undertaking treatment.

It has been my experience that sub-mucous cleft palate is a condition unknown and unrecognized by many in general medical, surgical and dental practice, whereas it is quickly recognised by surgeons concerned with the treatment of cleft lip and palate.

The following case histories are presented to illustrate this observation, and to stress the importance of accurate diagnosis by the speech therapist in the handling of these cases.

CASE A.

A European girl, 14 years of age.

She was referred for speech therapy three years previously with nasal speech. She received treatment at school for one year and at Clinic for one year. Further treatment was recommended but transport difficulties made this impossible. Improvement was negligible.

During the second year of treatment the possibility of a sub-mucous cleft palate was suggested, but not verified.

On Examination:

Hard Palate—there was no bony union for the posterior two-thirds of the hard palate. This V-shaped notch of the posterior border was easily visible and palpation was unnecessary. The oral mucosa was intact.

Soft Palate—there was a medial mucous line about 1/10th of an inch wide running from the base of the V of the hard palate the full length of the soft palate, which widened on phonation. This mucous line glowed red on illumination of the nasopharynx, confirming the absence of muscle union. The palate appeared short and the uvula was bifid.

Velopharyngeal closure was negative on tests and in speech. Articulation was correct but weak. There was consistent nasal tone.

This diagnosis of sub-mucous cleft palate was confirmed by the Plastic Surgery Unit, and surgery was undertaken. Further speech therapy should have followed immediately, but the girl had lost all interest and incentive and failed to attend in spite of arrangements being made to facilitate transport.

Had she been given the opportunity of surgical repair 2—3 years earlier, instead of the constant failure to improve with speech therapy, the results would probably have been more encouraging.

CASE B.

An Indian girl aged 9 years. Her home language was Ghurgurati and she attended an English medium school. She was referred from the Dental Hospital for examination and treatment on account of her very limited language ability. She presented a complicated picture. Her birth and early history and subsequent neurological examinations revealed the probability of her being a brain injured child. She was very small for her age and there was a history of earlier tubercular infection.

At birth the nose appeared flattened and was described by the father as being "almost absent." Feeding proved very difficult as the child could not suck, and there was regurgitation through the nose. There was no family history of cleft palate or speech defects. An examination at another speech clinic two years earlier, failed to reveal any palate abnormality.

On Examination:

Nose—bridge appeared flattened and nasal airways narrow. Teeth—malocclusion and abnormal structure of upper and lower incisors, (receiving treatment at time of examination). Hard Palate—there was a high narrow arch with a marked V shaped notch in the centre of the posterior border. Soft Palate—this appeared short and fairly mobile, there was a bifid uvula. Velopharyngeal closure was negative both on tests and in speech. There was an overall nasal tone and nasal escape. Articulation was grossly defective.

It seemed to me that this was a case of sub-mucous cleft palate and/or congenital short palate, in addition to a severe language retardation probably due to brain damage. However, controversial opinions were expressed regarding her palatal condition by others concerned with her treatment. She was then referred to a Plastic Surgeon for...
a further opinion. He reported that this was
certainly a case of sub-mucous cleft palate
and that the soft palate was definitely short.
On account of the child’s generally poor
physical condition, he advised that the case
should be reconsidered for the possibility of
surgical repair three years later. This exam-
ination should take place in 1957. It was
decided to treat the language disturbance in
the meantime, in spite of the complication of
grossly defective articulation and language
medium.

CASE C.

A coloured boy aged 11 years. This child
was referred for treatment by an Ear, Nose
and Throat Department, where he was receiv-
ing treatment for a discharging right ear. He
was referred as a repaired cleft lip and palate.
This was only partly true, his lip had been
repaired at 2 years of age, but there had been
no further operations of any kind.

His young stepmother could supply no in-
formation concerning his early development
and possible feeding difficulties. A sister, six
years younger, had a repaired double cleft
lip and palate. No other family incidence of
cleft palate or speech defect was reported.
The boy was very self-conscious of his grossly
defective speech and fought back when
 teased. When examined he was found to be
a friendly co-operative child and very anxious
to be helped.

On Examination:

Lip—There was a repaired right cleft lip,
the lip was mobile. Teeth—right upper pre-
molar and incisors were crooked. Hard
Palate—there was a high narrow arch par-
ticularly anteriorly, and a marked V shaped
notch medially at the posterior border. Soft
Palate—there was a central transparent
mucous line which widened on phonation,
and appeared as a red line when the naso-
pharynx was illuminated; the palate appeared
short with limited mobility and there was a
bifid uvula. Velopharyngeal closure
was negative on tests and in speech. Articulation—
was grossly defective with frequent use of the
glottal stop and speech was frequently unin-
telligible. There was an overall nasal tone.

The provisional diagnosis was sub-mucous
cleft palate associated with a right cleft lip
This was later confirmed by the Plastic Sur-
gery unit, where he was put on the list for
surgical repair. Speech Therapy was to be
postponed until after the operation.

CASE D.

A European boy of 6 years of age. He and
his sister were in the care of Child Welfare.
His mother was deceased and no early
history was available. His sister had a re-
paired cleft of the soft palate and normal
speech with the exception of sigmatism. The
boy’s was a case complicated by multiple
congenital abnormalities, spina bifida oculta,
hypertonia and dextrocardia with a cystolic
murmur. A few months before my examina-
tion the child had had encephalitis, and about
six months after examination poliomyelitis
(non-paralytic). He was very small for his
age and had not yet been to school. He had
been examined a few months earlier with a
view to special treatment but no mention was
made of a palatal abnormality.

On Examination:

Teeth—teeth were in a very poor condition
and the upper incisors had been extracted.
Hard Palate—there was no medial notch of
the posterior border, but the shape of the
posterior border resembled a wide V based
anteriortly and spreading laterally to the
regions of the hamular process. (I have only
once before seen this in a case of congeni-
tally short palate). The Soft Palate appeared
short with limited mobility, and on illumina-
tion of the nasopharynx a red mucous line
appeared down the full length of the soft
palate. The uvula was bifid. The pharynx
was wide laterally. Velopharyngeal closure
was negative. Articulation—there were some
articulatory errors, but speech was intelligible.
There was an overall nasality.

The provisional diagnosis of sub-mucous
cleft of the soft palate was later confirmed by
the Plastic Surgery Unit. There was no ques-
tion of operation for the time being, in this
case, on account of his general physical con-
dition and multiple abnormalities. It was
decided he should receive a short period of
speech therapy to ascertain what improve-
ment could be expected in spite of the con-
dition.

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